Topical Use of Cortisone in Erythema Multiforme Bullosum

Report of a Case

HAROLD C. FISHMAN, M.D., *Beverly Hills*

TOPICAL application of cortisone, a method of use on which no report could be found in the literature, was employed with good result in a case of vesicular and bullous dermatosis.

An 85-year-old white woman had been confined to bed for three years with paresis of the right arm and leg following a cerebral hemorrhage from hypertension. Cardiac decompensation also was present, and from time to time numerous drugs, including sedatives, diuretics, laxatives, and cardiac medications had been given. Three weeks before the patient was observed by the author, bullae and vesicles began to develop. When first observed the patient had many discrete bullae, ranging in size from that of a grape to that of a lemon, scattered heavily over the arms, legs, chest, abdomen and back. Many of the bullae were on a non-erythematous base. Nikolsky's sign was absent. There was one small ulcer in the mouth. On the back were many erythematous macular iris lesions. A diagnosis of erythema multiforme bullosum was made.

Dressings soaked in a 1:8000 solution of potassium permanganate were applied and Benadryl® was given by mouth. All former medication was discontinued, but on the advice of an internist digitalis therapy was started. New vesicles and bullae continued to appear and the condition of the patient appeared to be deteriorating. Cortisone was given intramuscularly, 200 mg. the first day and 100 mg. daily thereafter. The patient's spirit rose and there was some lessening of the discomfort from the bullae. Involution of the lesions was hastened somewhat, but at the end of three weeks of intramuscular cortisone therapy, new vesicles and bullae were still appearing. Although the patient felt much better, the clinical improvement was slight. A salve made of 100 mg. of cortisone and 240 gm. of a water-soluble base was applied liberally to all lesions twice a day. At the end of three days, 90 per cent of the lesions had involuted completely, leaving only slight erythema. The lesions which cleared included vesicles, bullae, herpes iris, and the dried hard black crusts remaining at the site of previously involuted bullae. At the end of a week almost every lesion had cleared, except for a few new vesicles. No undesirable side effects were observed.

SUMMARY

A severe case of erythema multiforme bullosum was treated topically with cortisone. The vesicles, bullae, drying crusts, and herpes iris lesions cleared quickly and dramatically after only slight improvement with cortisone given intramuscularly.

105 North San Vicente Boulevard.

Paroxysmal Hypertension Secondary to Malignant Pheochromocytoma

Report of a Case and Review of the Literature

GLEN O. CROSS, M.D., FRANK W. LUSIGNAN, M.D., and JOHN W. PACE, M.D., *San Francisco*

MALIGNANT, metastasizing pheochromocytomas producing paroxysmal hypertension have not been previously described in the medical literature.

In the case here reported the patient, first observed because of a tumor of the cervical spinal cord, was found to have paroxysmal hypertension in which a paroxysm could be precipitated by palpating a mass in the right side of the abdomen. This mass was a malignant pheochromocytoma and the spinal cord tumor was metastatic from it.

Only eight cases of malignant pheochromocytoma have been reported in the literature.[1, 2, 3, 4, 5, 6, 7, 8] Paroxysmal hypertension was not observed in any of these cases.

CASE REPORT

A 47-year-old white male was admitted to the hospital with complaint of inability to move the legs, weakness of the right arm and loss of bladder and bowel control. The illness was of two months' duration.

The patient had been well until attacks of headache, dizziness and a sensation of "pounding in the chest" began. These attacks were precipitated by excitement or by lying on the right or left side.

Four months prior to hospitalization the patient began to have aching pain in the right shoulder and a month later noticed tingling and numbness of the fingers of the right hand. Two months after this the patient awoke one morning unable to move the right leg and unable to initiate micturition. In the following month complete paraplegia developed, with loss of bowel and bladder control. Ulcers formed over the sacrum.

Upon admission to hospital the patient was emaciated. There was pronounced atrophy of the right arm and of both lower extremities. Frequent spasmodic movements of the legs were observed. There were three decubitus ulcers over the sacrum. The blood pressure was 130 mm. of mercury systolic and 90 mm. diastolic.

A firm, mobile mass about 10 cm. in diameter was palpated in the right upper quadrant of the abdomen. Manipulation of the mass precipitated an attack of dizziness, headache and palpitation of the heart similar to the spontaneous attacks previously described by the patient. The blood pressure was observed while the mass was being palpated and it rose from 130 mm. of mercury systolic and 90 mm. diastolic to 245 mm. and 145 mm. respectively. In association with this change, pronounced constriction of the retinal arterioles was observed ophthalmoscopically.

In examination of the cranial nerves no abnormalities were noted. There was a zone of hypalgesia and hypesthesia on the left side of the body below the level of the fourth cervical dermatome. There was mild hyperesthesia of the body below this level. Weakness of spastic type was noted in the right arm and both legs; it was most pronounced in the right leg. Reflexes were generally hyperactive and a positive Babinski response was elicited in the right foot. There was pronounced loss of tone of the anal sphincter.

Special Studies:

Blood cell counts were normal except that leukocytes numbered 13,450 per cu. mm. (The patient had cystitis.)

The spinal fluid was normal dynamically and chemically.